

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

I. Request Information

- A. The State of **Maryland** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.
- B. Waiver Title (optional): **Community Pathways Waiver**
- C. CMS Waiver Number: **MD.0023**
- D. Amendment Number (Assigned by CMS):
- E.1 Proposed Effective Date: **7/1/2019 12/1/2019**
- E.2 Approved Effective Date (CMS Use):

II. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The purpose of this amendment is to:

- (1) Update terminology related to the self-directed service delivery model in Appendix E;
- (2) To expand *Individuals and Family Directed Goods and Services* to include other goods and services that meet the service requirements therapeutic interventions to maintain or improve function including art, music, and dance therapies in Appendix C;
- (3) To add self-direction employer authority to *Employment Services* in Appendix E;
- (4) To clarify age requirements for meaningful day services (i.e. *Supported Employment, Employment Discovery and Customization, Employment Services, Day Habilitation, Career Exploration, and Community Development Services*). Age requirements will specify these services are for participants 18 years of age or older and no longer in high school as noted in Appendix C;
- (5) To clarify *Environmental Modifications* do not include elevators in Appendix C;
- (6) To clarify tuition includes post-secondary credit and noncredit courses in Appendix C;
- (7) To describe the three levels of *Shared Living* services in Appendix C;
- (8) To clarify specific services that support community integration and engagement can be provided in a variety of community settings that does not isolate or have qualities of an institution; best represents the preference of the person; and promotes their outcome goals and well-being in the community. To clarify specific services that support community integration and engagement shall not include disability specific classes, activities, events, or programs.
- (9) To outline the transition strategy for new services, rates, and fee-for-service billing process within Maryland's Long-Term Services and Supports (LTSS Maryland) which will start with a small group as noted in the Attachment #1: Transition Plan; and
- (10) To update information and add new procedure codes and associated rates for services including dedicated staffing (i.e. 1:1 and 2:1) in *Community Living- Group Home and Supported Living* services; *Shared Living* levels; *Day Habilitation* (small and large groups); and an enhanced

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Personal Supports rate for people with complex health and/or behavioral needs in Appendix I and J.

The purpose of this amendment is to continue to: (1) support DDA's five priority focus areas (employment, self-determination, self-direction, supporting families, and supported housing); (2) align the waivers with DDA's transformation and incorporate feedback received through DDA transformation meetings, trainings, and presentations; (3) support program integrity (e.g. quality assurance/federal performance measures, protect people's rights, prevent fraud); and (4) ensure fiscal accountability.

The first amendment will include programmatic adjustments, such as:

1. Alignment of the services scope, requirements, limitations, qualifications, and effective date for the three home and community-based service waivers programs that support individuals with developmental disabilities which includes the Family Supports Waiver, Community Supports Waiver, and the Community Pathways Waiver.
2. Adjustment of some of the service implementation to provide additional time for rate setting and development of critical operational and billing functionality.

Notable changes in each Appendix in this amendment include:

Appendix A

Updates to the transition plan based on the amendment.

Appendix B

1. Increases to the projected number of individuals served (i.e. slots) to account for additional people enrolled in year 1 and future enrollment projections.
2. Adjustment to reserved capacity projections based on current experience and future projections.
3. Addition of two new reserved capacity categories including Department of Human Services (DHS) Foster Kids Age Out and Maryland State Department of Education (MSDE) Residential Age Out.

Appendix C

1. Alignment of services scope, requirements, limitations, qualifications, and effective date for the DDA home and community-based waivers;
2. Adjustment of some service effective dates from July 2019 to July 2020 to provide additional time for rate setting and development of critical operational and billing functionality;
3. Changes in behavioral support services qualification requirement including clinician experience and competencies and support staff behavioral technician training;
4. Changes in career exploration, including the clarification of time limited for new users with authorization for up to 720 hours for the plan year;
5. Increase flexibility in nursing case management and delegation services to provide the option to authorize additional hours under residential services such as Community Living Group Home services due to change in condition after a hospital or skilled nursing facility discharge;
6. Improvements to respite that include (1) a daily rate will be used for licensed sites and hourly rate for in/out of home services; (2) increase service to include a daily/hourly limit up to 720 hours/year plus up to \$7,248 toward camps; and (3) adjustment to staff qualifications (i.e. GED/HS Diplomas/Age requirements);
7. Enhancements to shared living specifying various supports;
8. Addition of support brokers as a waiver services;

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- ~~9. Change of terminology related to DDA approved providers to DDA certified providers; and~~
- ~~10. Updates to criminal background checks including new draft requirements.~~
- ~~11. Updates to environmental assessment and environmental modifications to support participants in community living group home and community living enhanced supports with new accessibility needs (e.g. grab bars, ramp, stair glide, etc.) to support health, safety, access to the home, and independence.~~

Appendix E

- ~~1. Removal of support broker services as an administrative service;~~
- ~~2. Addition of support broker as a waiver service to support information and assistance in support of participant direction; and~~
- ~~3. Addition of budget authority for support broker services~~

Appendix I and J

- ~~1. Addition of support broker waiver services;~~
- ~~2. Adjustments to estimated users and projections;~~
- ~~3. Adjustment to behavioral support consultation services from an hourly unit to a fifteen minute unit; and~~
- ~~4. Payment systems will transition to Maryland's Long Term Services and Supports (LTSSMaryland) system on July 1, 2020.~~

III. Nature of the Amendment

- A. Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

	Component of the Approved Waiver	Subsection(s)
<input checked="" type="checkbox"/>	Waiver Application	II. Purpose; 6. Additional Information; Attachment #1
<input type="checkbox"/>	Appendix A – Waiver Administration and Operation	
<input type="checkbox"/>	Appendix B – Participant Access and Eligibility	
<input checked="" type="checkbox"/>	Appendix C – Participant Services	C-1/C-3
<input type="checkbox"/>	Appendix D – Participant Centered Service Planning and Delivery	
<input checked="" type="checkbox"/>	Appendix E – Participant Direction of Services	
<input type="checkbox"/>	Appendix F – Participant Rights	
<input type="checkbox"/>	Appendix G – Participant Safeguards	
<input checked="" type="checkbox"/>	Appendix I – Financial Accountability	I-2
<input checked="" type="checkbox"/>	Appendix J – Cost-Neutrality Demonstration	J-1; J-2

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B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

<input type="checkbox"/>	Modify target group(s)
<input type="checkbox"/>	Modify Medicaid eligibility
<input type="checkbox"/>	Add/delete services
<input checked="" type="checkbox"/>	Revise service specifications
<input type="checkbox"/>	Revise provider qualifications
<input type="checkbox"/>	Increase/decrease number of participants
<input checked="" type="checkbox"/>	Revise cost neutrality demonstration
<input type="checkbox"/>	Add participant-direction of services
<input type="checkbox"/>	Other (specify):

IV. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding this amendment is:

First Name:	Marlana R.
Last Name	Hutchinson
Title:	Deputy Director, Nursing and Waiver Services
Agency:	Maryland Department of Health – Office of Long Term Services and Supports (OLTSS)
Address 1:	201 West Preston Street, 1 st Floor
Address 2:	
City	Baltimore
State	Maryland
Zip Code	21201
Telephone:	(410) 767-4003
E-mail	marlana.hutchinson@maryland.gov
Fax Number	(410) 333-6547

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- B. If applicable, the operating agency representative with whom CMS should communicate regarding this amendment is:

First Name:	Rhonda
Last Name	Workman
Title:	Director of Federal Programs
Agency:	Maryland Department of Health – Developmental Disabilities Administration
Address 1:	201 West Preston Street, 4 th Floor
Address 2:	
City	Baltimore
State	Maryland
Zip Code	21201
Telephone:	(410) 767-8690
E-mail	Rhonda.Workman@maryland.gov
Fax Number	(410) 333-5850

V. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

Date:

State Medicaid Director or Designee

First Name:	Robert R.
Last Name	Neall
Title:	Secretary
Agency:	Maryland Department of Health
Address 1:	201 W. Preston Street
Address 2:	5 th Floor
City	Baltimore
State	Maryland
Zip Code	21201
Telephone:	410-767-4639
E-mail	Robert.neall@maryland.gov
Fax Number	410-767-6489

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1. Request Information

A. The State of **Maryland** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. **Program Title** (optional – this title will be used to locate this waiver in the finder): **Community Pathways Waiver**

C. **Type of Request:** (the system will automatically populate new, amendment, or renewal)

Requested Approval Period: (For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)

	3 years
X	5 years

<input type="checkbox"/>	New to replace waiver Replacing Waiver Number: 	
<input type="checkbox"/>	Migration Waiver – this is an existing approved waiver Provide the information about the original waiver being migrated	
	Base Waiver Number:	
	Amendment Number (if applicable):	
	Effective Date: (mm/dd/yy)	07/01/2018

D. **Type of Waiver** (select only one):

<input type="radio"/>	Model Waiver
<input checked="" type="radio"/>	Regular Waiver

E. **Proposed Effective Date:** July 1, 2018

Approved Effective Date (CMS Use): July 1, 2018

F. **Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s)

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of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

<input type="checkbox"/>	Hospital (<i>select applicable level of care</i>)
<input type="radio"/>	Hospital as defined in 42 CFR §440.10 If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
<input type="radio"/>	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
<input type="checkbox"/>	Nursing Facility (<i>select applicable level of care</i>)
<input type="radio"/>	Nursing Facility as defined in 42 CFR §440.40 and 42 CFR §440.155 If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
<input type="radio"/>	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
<input checked="" type="checkbox"/>	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150) If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID facility level of care:

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

<input checked="" type="radio"/>	Not applicable	
<input type="radio"/>	Applicable	
	Check the applicable authority or authorities:	
<input type="checkbox"/>	Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I	
<input type="checkbox"/>	Waiver(s) authorized under §1915(b) of the Act. <i>Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:</i>	
	Specify the §1915(b) authorities under which this program operates (<i>check each that applies</i>):	
<input type="checkbox"/>	§1915(b)(1) (mandated enrollment to managed care)	<input type="checkbox"/> §1915(b)(3) (employ cost savings to furnish additional services)

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<input type="checkbox"/>	§1915(b)(2) (central broker)	<input type="checkbox"/>	§1915(b)(4) (selective contracting/limit number of providers)
<input type="checkbox"/>	A program operated under §1932(a) of the Act. <i>Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:</i>		
<input type="checkbox"/>	A program authorized under §1915(i) of the Act.		
<input type="checkbox"/>	A program authorized under §1915(j) of the Act.		
<input type="checkbox"/>	A program authorized under §1115 of the Act. Specify the program:		

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

<input checked="" type="checkbox"/>	This waiver provides services for individuals who are eligible for both Medicare and Medicaid.
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2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Community Pathways Waiver is designed to provide **integrated** support services to individuals and their families, to enable participants' to work toward self-determination, independence, productivity, integration, and inclusion in all facets of community life across their lifespans. It supports individuals and families as they focus on life experiences that point the trajectory toward a good quality of life across the lifespan. Services can support integrated life domains that are important to a good quality of life, including daily life, safety and security, community living, healthy lifestyle, social and spirituality, and citizenship and advocacy. These services will build on each participant's current support structures to work toward individually defined life outcomes, which focus on developing the participant's abilities for self-determination, community living, socialization, and economic self-sufficiency.

The goals for the Community Pathways Waiver include:

- Innovative service options aimed at providing supports that build on the DDA's existing Community of Practice related to Employment and Supporting Families;
- Participant and family self-direction opportunities;
- New Supported Living and housing support services to increase independent living opportunities; and
- Transitioning to new Employment Services and provider rates.

As an Employment First State, Meaningful Day and Employment services are predicated on the belief that all individuals with developmental disabilities can work when given the opportunity, training and supports that build on an individual's strengths. Employment is the first service considered but not the only choice. The intent of services and supports are to increase individual independence and reduce level of service needed.

Waiver Organizational Structure:

The Maryland Department of Health (MDH) is the single state agency for Medicaid. MDH's Office of Long Term Services and Supports (OLTSS) is responsible for ensuring compliance with federal and state laws and regulations to the operation of the waiver. MDH's Developmental Disabilities Administration (DDA) is the operating state agency and funds community-based services and supports for people with developmental disabilities. The DDA has a Headquarters (HQ) and four Regional Offices (RO): Central, Eastern, Southern, and Western.

The DDA utilizes various agents, licensed providers, and contractors to support the administrative, operations, and direct service delivery. Medicaid State Plan targeted case management (TCM) services are provided by licensed Coordination of Community Services (CCS) agencies. The MDH's Office of Health Care Quality (OHCQ) performs licensing, surveys, and incident investigations.

Participants will receive case management services, provided by licensed Coordination of Community Services (CCS) providers, through the Medicaid State Plan Targeted Case Management (TCM) authority. Each Coordinator of Community Services assists participants in developing a Person-Centered Plan, which supports individual health and safety needs being met. The coordinator is also responsible for conducting monitoring and follow-up to assess the quality of service implementation.

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Services are delivered under either the Self-Directed or Traditional Service Delivery Models provided by qualified providers (i.e. individuals, community-based service agencies, vendors and entities) throughout the State. Services are provided based on each waiver participant's Person-Centered Plan to enhance the participant's and his/her family's quality of life as identified by the participant and his/her family through the person-centered planning process.

Services are provided by DDA-licensed and DDA-certified community agencies and/or individuals and companies under the self-directed service delivery model. Providers offering career exploration facility-based supports, day habilitation, licensed respite, community living - group home, and community living - enhanced supports waiver services must meet provider qualifications and have their provider owned and/or operated sites licensed. Services provided in the community or the person's own home such as employment services, personal supports, respite, and assistive technology and services must meeting provider qualifications to be certified by the DDA. Fiscal Management Services (FMS) and Support Brokerage services are also provided for individuals that use the self-directed service delivery option. This organizational structure provides a coordinated community-based service delivery system so that people receive appropriate services oriented toward the goal of full integration into their community.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. **Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. **Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. **Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. **Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. **Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

<input checked="" type="radio"/>	Yes. This waiver provides participant direction opportunities. <i>Appendix E is required.</i>
<input type="radio"/>	No. This waiver does not provide participant direction opportunities. <i>Appendix E is not required.</i>

- F. **Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. **Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. **Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. **Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

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- J. Cost-Neutrality Demonstration.** Appendix J contains the State’s demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

<input type="radio"/>	Not Applicable
<input type="radio"/>	No
<input checked="" type="radio"/>	Yes

- C. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):

<input checked="" type="radio"/>	No
<input type="radio"/>	Yes

If yes, specify the waiver of statewide that is requested (*check each that applies*):

<input type="checkbox"/>	<p>Geographic Limitation. A waiver of statewide is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.</p> <p><i>Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:</i></p>
<input type="checkbox"/>	<p>Limited Implementation of Participant-Direction. A waiver of statewide is requested in order to make <i>participant direction of services</i> as specified in Appendix E available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.</p> <p><i>Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:</i></p>

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
- As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

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2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services.

Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided

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as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process

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of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified throughout the application and in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:

The DDA partners with people in services, self-advocates, family members, service providers, advocacy organizations, and subject matter experts to enhance services and supports for Marylanders with developmental disabilities. This partnership includes working with various groups related to employment, self-direction, supporting families, person-centered planning, coordination of services, supporting children, training, system platforms, and rates.

The DDA also shares information and overviews of the waiver and services for various groups. These events provide opportunities to obtain additional information, input, and recommendations from participants that can influence waiver services, policies, and procedure changes.

The DDA recognizes and appreciates the diversity of input we receive from stakeholders. We carefully considered input and recommendations from people with developmental disabilities and various stakeholders for changes to our services, processes, and policies. The amendment is a result of input and recommendations the DDA received from stakeholders.

The following list of groups, meetings, subject matter experts, and presentations include:

Employment First Webinars related to Meaningful Day Services held July, August and November of 2018

Provider stakeholder group meetings held July 25th and September 7th, 2018

Tiered Standards Leadership Team meetings held July 7 and September 12, 2018

Employment First State Leadership Team meetings held July, August, September, November and December of 2018

DDA presentations at the Maryland State Department of Education (MSDE) Professional Learning Opportunities (PLO) –on four dates in November 2018

Multiple in-person meetings with DDA licensed or certified provider organizations to share information, provide technical assistance for compliance with the community-settings requirements, and obtain input new opportunities, challenges, and concerns.

Monthly Statewide Behavior Supports Committee meetings related to behavioral supports services to include seeking input related to staff qualifications, requirements, and training.

The DDA Transformation Advisory Committee held meetings to share information and obtain input related to transformation efforts including waiver services challenges and concerns on June 12, 2018, September 10, 2018, October 25th 2018, November 16, 2018 December 6, 2018, and January 11, 2019

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The DDA Coalition Meetings held July 10, 2018, August 2, 2018, and December 19, 2018

The Maryland Association of Community Services meeting September 13, 2018

The Self-Directed Advocacy Network (SDAN) held quarterly meetings.

The Applied Self-Directions (ASD) monthly calls hosted subject matter experts to discuss various service delivery components related to self-directed services including training and curriculum development; waivers services; and national best practices.

The Service Authorization Work Group held four meetings in July and one in August of 2018 to obtain input related to services authorization and billing criteria.

The Community Coordination Coalition (CCC) service delivery system and waiver services input monthly.

The Technical Work Group shared information and obtain input related to services and rates on June 13, 2018, August 10, 2018, August 31, 2018, and October 26, 2018.

Long Term Services and Supports Provider Work Group shared information and obtain input related to the service delivery system and waiver services monthly from July 2018 to January 2019

DDA Public Presentations examples including:

1. The Hussman Institute – Self-Directed Service Delivery Model presentation on July 24, 2018
2. Maryland Association of Community Services General Membership Meeting - DDA updates on September 13, 2018
3. Quality Trust – Understanding the DDA Waivers on October 20, 2018 and DDA Service Delivery Models on November 3, 2018
4. Transition Resource Fair - Navigating Toward Independence – Overview of the DDA Service Delivery Models on November 17, 2018
5. Maryland Association of Community Services (MACS) Conference - DDA Hot Topics including waiver amendments on November 30, 2018
6. Kennedy Krieger Institute – DDA Overview including waivers and services on December 7, 2018
7. Parents Place of Maryland – DDA Overview including waivers and services on January 25, 2019

DDA Transformation Newsletter and Email

On April 30, 2019, the DDA sent out information to all stakeholders and partners regarding the Waiver Amendment #2 application and upcoming public meetings regarding changes to self-directed services. On May 3, 2019, the DDA sent out information regarding public meetings to share information related to the self-directed services framework and infrastructure and Waiver Amendment #2 self-direction enhancements. On May 23, 2019, the DDA sent out information regarding public meetings to discuss the transition process to fee-for-services within LTSS Maryland and next steps. On June 10, 2019, the DDA sent out a reminder about the June 14th webinar overview of the DDA Waivers Amendments # 2 2019 proposals.

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On January 17, 2019, the DDA sent out information to all stakeholders and partners regarding the Waiver amendment application and upcoming overview webinars. In addition, information about the upcoming amendment has been shared in the DDA Transformation Newsletter including the September 18, 2018 and January 23, 2019.

Dedicated DDA Amendment Webpage

The DDA established a dedicated DDA Waivers - Amendment #2 2019 webpage and posted information about the draft waiver amendment application, and the public webinar presentation. The website is located at: <https://dda.health.maryland.gov/Pages/DDAWaiversAmendment2-2019.aspx>.

The DDA established a dedicated DDA Waivers – Amendment #1 2019 webpage and posted information about the draft waiver amendment application, and the public webinar presentation. The website is located at: https://dda.health.maryland.gov/Pages/DDA_Waivers-Amendment1-2019.aspx

Public Meeting and Webinar Amendment Overview

Public meetings regarding the self-directed services delivery model framework and enhancements were conducted on May 13th for the Central and Southern regions, May 16th for the Eastern Shore, and May 20th for the Western region. All meetings were conducted from 6 p.m. to 8 p.m. to hear participants shared suggestions, recommendations, concerns, and provide an opportunity for questions.

Public meetings regarding the transition strategy to the new LTSS Maryland fee-for-service billing methodology and new procedure codes and associated rates associated with dedicated staffing (i.e. 1:1 and 2:1) in residential services; shared living levels; day habilitation (small and large groups); and enhanced personal supports rate were conducted on June 3rd for the Central Region, June 6th for the Eastern Shore, June 10th for Southern Maryland, and June 13th for Western Region. Meetings were conducted from 3 to 5 p.m. and 6 to 8 p.m. on each day to hear participants shared suggestions, recommendations, concerns, and provide an opportunity for questions. The same presentation was provided at both times.

The DDA also conducted a webinar overview of the DDA Waivers Amendments # 2 2019 final proposals on June 14, 2019.

The DDA conducted webinars on February 2, 2019 and February 4, 2019 f to share an overview of the proposed amendment. The same presentation was provided at both times. The DDA also held a meeting on February 11, 2019 from 6:30 to 8:30 p.m. to hear participants shared suggestions, recommendations, concerns, and provide an opportunity for questions.

Formal Public Comment Period

The Maryland Urban Indian Organization (UIO) was notified on ~~May 23, 2019~~ February 1, 2019.

Request for public input was also posted in the Maryland Register (Issue Date: June 7, 2019), which is available electronically or in hard copies as well as in different languages and formats to ensure accessibility statewide at the local health departments, DDA Headquarter Office and DDA Regional Offices.

The official public comments period will begin June 15, 2019 through July 14, 2019. Public comments can be submitted to wfb.dda@maryland.gov or mailed to DDA Federal Programs at

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201 West Preston Street, 4th Floor, Baltimore MD 21201 on June 15, 2019 through July 14, 2019. To support the stakeholder input process and minimize public burden, comments for all three waivers should be submitted together under one response. In total, 132 unduplicated individuals, families, providers, and advocacy agencies submitted input for the three DDA Waiver Amendments. Below is a summary of the specific recommendations from the public and responses. A complete listing of DDA's responses are posted to the DDA dedicated Amendment #2 2019 website.

A comment for the Introduction/Purpose of the Amendment that stakeholder feedback seems inflated. The DDA explained it receives recommendations, comments, and concerns related to services and will continue to partner with people in services, self-advocates, family members, service providers, advocacy organizations, and subject matter experts to enhance services and supports. The DDA will continue to share information and overviews of the waiver and services through various means.

The DDA accepted recommendations to engage the Technical Provider group more often and to give at least a 10 day notice for all stakeholder meetings and webinars. The DDA did not accept recommendations to postpone Amendment #2 submission and offer a second public input period. The DDA continues to share and engage with stakeholders related to waiver services, policies, and rates. Thirty day comment periods are offered prior to each waiver submission.

Comment that "Attachment 1: Transition Plan" is not available on website. The DDA responded the information is found within the "Purpose of HCBS Waiver Program and Appendix A" on the website.

Recommendation to adopt a "hold-harmless" policy to assure participants not experience a sudden loss of services. The DDA is working with an independent consultant and the Provider Tech Group with the ongoing process of the new rate development, validation, and verification.

The DDA received several comments to remove or amend the language added in Community Development Services, Personal Supports, Shared Living, and Supported Living around community integration not including disability-specific classes, activities, events or programs, as it is restrictive. The DDA responded that its intent is to support community inclusion and prevent the creation of specific disability services while supporting people's choice, preferences, and inclusion. The DDA revised the service definition language to be more inclusive.

Recommendation to include reasonable activity costs in Day Hab, CDS, Personal Support and Community Living was not accepted, as Medicaid waivers do not pay for activity costs.

Comment that community no longer including a person's home is restrictive. The DDA clarified that several services can be provided in the home.

The DDA received recommendations to clarify provider requirements and remove the requirement for a DDA provider application for individuals providing services under self-direction. The DDA explained that individuals acting as private vendors must completed an application; those hired by a DDA agency do not need to complete an application.

The DDA received several comments in Appendices C and E related to the role and scope of Support Broker services. They were not accepted. The DDA clarified the role of Support Brokers has not been limited and no changes were made to the service scope. This service includes information, coaching, and mentoring related to roles and responsibilities and functioning as the

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common law employer and assistance in learning skills and developing agreement, strategies to manage and oversee services. Initial start up refers to the initial information, coaching and mentoring a Support Broker would provide; CCSs facilitates and assists with the PCP development. Participants determine the level and extent of support they receive from Support Brokers; they can share reports with Support Brokers, if they choose. The DDA did not accept recommendations to allow participants in residential services to self-direction, as opportunities are available for individuals who live with others under a lease. The DDA did not accept recommendations to give budget and employer authority to all services with a self-directing option; specific professional standards, training requirements, and provider qualification requirements have been established for each waiver services to support participants' health and safety and ensure qualified providers.

Recommendations related to Criminal Background checks included: 1) keeping the language the same as Amendment #1 and 2) replacing language to waive the checks for those who self-direct. The DDA explained that the language is the same in Amendment # 1 and # 2, and that background checks can be waived only if the behavior is not harmful to an individual with a developmental disability.

Comments that multiple day services are complex and a new day service with a daily rate should be added were not accepted. The DDA explained that unbundling services allows for flexibility and identified rates for each service.

The DDA agreed to explore a new "Tiered Standard," and will share the information with the Tiered Standards advisory group.

Comment that Community Development Services, Employment Services, and Personal Support services should not include the personal care limitation. The DDA explained that Personal Supports is habilitative; assistance with activities of daily living can be addressed through the Medicaid State Plan.

The DDA accepted a recommendation to clarify that nurse health case management is not required to people using Employment Services, Supported Employment, Community Development Services, Career Exploration, and Day Hab. It is based on an assessed need.

The DDA did not accept recommendations to remove mileage reimbursement restriction for Community Development and Personal Support staff, as transportation is part of the rate for these services.

Recommendation that the DDA provide information on specific training requirements for services, as it is burdensome to providers. The DDA is working with stakeholders to develop a training policy for direct support professionals.

Comment the State should provide funding to supplement housing and room and board costs. The DDA is currently reviewing room and board requirements and the corresponding rate.

The DDA did not accept recommendations to reconsider the use of "exhaustion" and other funding language as it relates to service access. The DDA explained this a CMS requirement. If the service is not available or appropriate, DDA will authorize services.

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Recommendations were not accepted to remove and/or amend requirements for relatives/legal guardians to provide services. The DDA explained the State must provide criteria for when payment can be authorized for a relative/legal guardian.

Recommendations related to Fiscal Management Services (FMS) to bring on new FMS after LTSS has proven successful was not accepted, as FMS functions are not within LTSS. Recommendations to make FMS a waiver service were not accepted; FMS will continue to be an administrative service.

Five comments were received related to Career Exploration. The DDA accepted a recommendation criteria of when a person can request the service again. The DDA did not accept recommendations to remove the reauthorization restriction, or to allow the service regardless of when the participant began accessing it. Career Exploration is a time limited service and is not necessary for a person to be supported in Competitive Integrated Employment (CIE). Concerns that language regarding groups completing contract work and ongoing job supports were expressed. The DDA explained that ongoing job supports allows for situations that meet CIE criteria.

Ten comments related to Community Development Services. Recommendations to add a method of oversight to ensure people are engaged in meaningful day activities. The DDA explained that this is done through the PCP. The DDA did not accept suggested language related to services in the home or community, and self-employment. CDS is provided in the community and self-employment can be supported under Employment Services. Recommendation that Personal Supports should be provided during CDS was not accepted, as it would be a conflict. Personal care assistance, however can be provided during CDS. Comment that First Aid/CPR and training language conflicts with self-direction. The DDA explained that self-direction participants can require additional training.

Three comments related to Day Hab. The DDA did not accept a comment providers should be able to bill for transportation time, as transportation is included in the service and rate. A comment to clarify “generic” internships. The DDA removed the word “generic” to prevent confusion.

A comment to allow employer authority for Employment Discovery and Customization was not accepted. This service is budget authority only to ensure qualified providers.

Fifteen comments related to Employment Services. The DDA clarified that Employment Services will begin on December 1, 2019. The DDA accepted a recommendation to only require a job development plan for a person that is entering job development for Discovery milestone #3. Comments related to staff employment certification exams included: 1) it being an obstacle to employment; and 2) staff should be permitted to pass the exam 6 months after completing the required experience. The DDA explained that the job development staff requirements are based on best practices. Employment specialists that do not have the requirements to provide this service must have all their work approved by a Certified Employment Support Professional (CESP) supervisor. Comment that time frames on volunteerism and internships in discovery should be flexible. The DDA explained that volunteering is available in CDS, Day Hab and Career Exploration. Per CMS guidance, volunteering does not fall under this service. Recommendation to add language to Discovery limitation around individual circumstances. The DDA explained that similar language is in the service guidance. Recommendations related to Follow Along service included extending the service beyond 6 months and a policy that individuals maintain eligibility in the event of a crisis. The DDA explained that there is no time limit. Comments

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related to self-employment included ensuring ongoing supports is available and funding is not sufficient to support initial business planning were not accepted. The DDA explained that ongoing supports and follow along are available, and that Medicaid does not defray start up business costs. The service is designed to assist with business and marketing plan development. Recommendations related to Ongoing Job Supports include: 1) add language related to criteria to access service; 2) increasing the daily limit to 12 hours; and 3) services, along with other meaningful day services, should not be limited to 40 hours per week. The DDA explained similar language is currently in waiver and agreed to monitor utilization and adjust if necessary.

Recommendation that DDA required and in-service PCP training for Environmental Assessment, Environmental Modifications and Housing Support professionals is restrictive and should be removed was not accepted. The DDA explained that providers must complete both DDA required and person-specific training based on the PCP prior to service delivery.

Recommendation that self-directing participants have employer authority for Family and Peer Mentoring supports since DDA does not have providers. The DDA clarified there are 48 certified providers for this service.

Eight comments related to Individual and Family Directed Goods and Services. The DDA accepted recommendations to add language expand services, including Music Therapy. *However after review by CMS, the State was advised therapeutic interventions services under IFDGS should not have been previously approved by CMS.* Recommendations to fund activity fees, “noncredit” courses and those not funded through DORS were not accepted. Participants can use their personal funds or explore Participant Education, Training and Advocacy Support for such opportunities. Recommendation to offer this service under the traditional service model was not accepted. The DDA explained this service is limited to waivers that allow Budget Authority participant direction options. Recommendation that therapies should be under Category 11: Other Health and Therapeutic Services. The DDA explained medically necessary therapies recommended by clinicians are covered under Medicaid. Comment that participants should not be capped or have to find savings to access was not accepted, as services are purchased from the participant-directed budget savings.

Recommendation for Live-In Caregiver Support to alter recipient of payment to address self-directing participants with unpaid live-in caregivers. The DDA explained this service is available for those in self-direction.

Recommendation for Nurse Consultation that an RN be able to carry “Professional Liability Insurance,” instead of Commercial Liability Insurance. The DDA explained commercial insurance is required if the RN is an agency; professional insurance would be required if the RN is an employee.

Recommendation to review the 10 hour limitation for Participant Education, Training and Advocacy Supports was accepted.

Eighteen comments related to Personal Supports. The DDA accepted recommendations to include criteria for “enhanced personal support services.” Recommendation to have safeguards to ensure self-directing participants’ rights are protected. The DDA explained this is addressed in Appendix E. Recommendations to reconsider personal care compromising the service, cover awake overnight, and offer this service whether habilitative or not, were not accepted as Personal Supports services are habilitative in nature. People with a medical need for overnight services may receive support through the Medicaid State plan. Recommendation to allow this service in a

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licensed site were not accepted, as this would be a duplication of services. Concerns about a schedule related to how service is used. The DDA explained information, including a schedule, is requested to identify appropriate services to address assessed needs. Recommendations to reword and amend service definition related to when and where it can be accessed and self-direction exceptions were not accepted. The DDA works with stakeholders related to service delivery. Authorized services are based on an assessed need.

Two recommendations were received related to Respite. The DDA did not accept a recommendation to include an enhanced service, as behavioral respite services exist through a contract with independent community organizations. Recommendation to clarify how to bill for the service. The DDA explained a daily rate is billed when services are in a licensed residential site; an hourly rate is used when services are provided in the participant's home or non-licensed respite provider's home up to 24 hour in a day. Both daily and hour respite can be used up to a total of 720 hours per year.

Eight comments were received for Shared Living. The DDA did not accept recommendations to add language allowing relatives to support participants through this service, and to remove the lack of family support requirement, as it is designed to for participants who do not have family support. There are residential support models where relatives may be able to support the person. The recommendation to remove "frequent" from Service Requirement D was not accepted; the current requirement allows for people who may require moderate assistance. The DDA will issue service guidance. The DDA did not accept recommendation to remove references to legally responsible persons or legal guardians, as the service is not designed for them to provide supports. Recommendation to allow for budget authority was not accepted. This service is not under self-direction to ensure that providers are qualified.

The DDA did not accept the two comments submitted for Supported Employment. Volunteerism was removed from Supported Employment per CMS guidance. Participants can volunteer under CDS, Day Hab, and Career Exploration. Small and large group supports do not meet the criteria for Follow Along and Ongoing Job Supports, which supports CIE.

Four recommendations were received related to Supported Living. The DDA accepted a recommendation to allow a married couple who both receive supports, a parent who receives supports and their child, and siblings who both use supports to use this service. Recommendation to the new "enhanced supported living" category to the service definition. The DDA explained no changes are needed, as staffing needs are noted in the description and detail service authorization of the PCP.

The DDA responded to a recommendation to support anyone moving into residential services under Transition services, that this is not allowed per CMS guidance.

Six comments were received related to Transportation. The DDA did not accept a recommendation to allow legally responsible person and guardians to be paid for the service; as it is not a for participant relatives. The DDA accepted a recommendation to define "Accessing Mobility," stating that it will be included in service guidance. Recommendation to return all transportation services to a standalone category for Self-Direction was not accepted. Comment that transportation being included in some services and not others may cause unnecessary complexity. Comment to clarify if self-directing participants are restricted to reimburse staff for mileage. The DDA explained that historically staff support and transportation have been included in Meaningful Day services. People self-directing can designate funding in their self-directed budget to address this need.

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The DDA clarified that vehicle modifications can be made to the participant’s primary means of transportation.

Twenty comments were received for Appendix E. A comment that self-direction ensures safety of loved ones. The DDA explained that information about self-direction is shared by participants and their families by the CCS. The DDA accepted recommendations to define Designated Representative in regulations and guidance, and add language in the waiver for clarity, and align it with Family Supports and Community Supports Waiver. The DDA explained that a designated representative is not required, but an option a person can choose. A recommendation to restore Independence Plus Designation. The DDA explained it was directed by CMS to unselect this designation due to some services only being available under the traditional service model. A comment that family and spouses should have the same employment standards as others, including overtime. The DDA explained that legally responsible individuals are not eligible for Federal financial participation, per CMS policy. Recommendation to allow staff paid leave while pay for backup staff. The DDA responded staff benefits and leave time are an option under self-directed services delivery model; requirements are outlined in the waiver application. Recommendation to allow participants to move funds around in their budget plans, without DDA approval. The DDA explained that this is the case for some services but all changes need to be documented in the PCP.

The DDA provided clarification for the seven comments received for Appendix I. Comments that proposed rates would incentivize larger group settings for Community Living and one to one staff support for Employment Services. The DDA explained there are rates associated with dedicated supports to support the transition into the new fee for service payment methodology. A comment that the percent in the “brick” for services that include transportation is not sufficient for persons with wheelchairs or people out in the community daily multiple times. Funding is needed for the purchase of vehicles. The DDA explained that transportation to and from and within a service is included within the services and rate. The least costly and most appropriate means of transportation will be provided or arranged by the licensed provider and funded through the rate system. Comment that hourly and partial hourly billing units need to include a system for rounding that is reasonable, no geographical differential is listed, and the rates would result in significant funding changes from current funding. The DDA is working with an independent consultant and the Provider Tech Group with the ongoing process of the new rate development, validation, and verification; once completed, updated information will be shared as part of Waiver Amendment #3. Comment that information provided in Appendices C, I, J does not align completely service by service, and conflicts with information provided to the Technical Workgroup. The DDA explained discrepancies are due to the ongoing process of the rate development and the need to submit an amendment to include all services so the pilot for LTSS can proceed. The timing of these activities are not in alignment. Another waiver amendment will be submitted when the rates have been finalized. Recommendations for further analysis and refinement of Day Habilitation rate structure, and consideration of acuity, Bureau of Labor Statistics (BLS) wage and training for the Personal Supports regular and enhanced services. The DDA explained the final rate components will be shared and noted in Amendment # 3.

Two recommendations were received for Appendix J. The DDA accepted recommendations to explore day/employment services be billable in 15-minute increments and to provide an updated “Brick” table with supporting documentation regarding the data, methodology and assumptions used for each rate. Updated Brick information will be shared once verification and validation has been completed and as part of Waiver Amendment # 3.

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From February 2, 2019– March 3, 2019, stakeholders had the opportunity to provide input on the proposed amendment. Request for public input was also posted in the Maryland Register on February 1, 2019, which is available electronically or in hard copies as well as in different languages and formats to ensure accessibility statewide at the local health departments, DDA Headquarter Office and DDA Regional Offices.

The formal public comment period for Amendment #1 2019 proposal was held from February 2, 2019– March 3, 2019. In total, 110 unduplicated individuals, families, providers, and advocacy agencies submitted input. Below is a summary of responses received during the public comment period and the Developmental Disabilities Administration’s (DDA) responses. A complete listing of all responses can be found on the DDA website.

The DDA received a comment of appreciation and support of amendments intended to bring about consistency and clarity across the three waivers. Nine comments related to language changes in the Purpose of the HCBS Program section. Suggested language changes included: specifying input from innovative processes be required; requiring specific training for coordinators of community services (CCSs), caregivers, and staff; providing emergency funding; and using the words “employees”, “employees and vendor staff” and “vendor staff” when appropriate were not accepted. The DDA explained the input process, current training requirements, the availability of emergency funding, and why “employee” was used. Accepted suggestions include clarifying CCSs’ monitoring roles and responsibilities and services intent for increasing independence.

Three comments were received for Appx. A. Providers’ suggestions to remove discharge language from nursing case management and delegation and comments regarding the age limit of respite providers were not accepted. The DDA explained that delegation may be needed after discharges, and lowering the required age limit of respite providers to 16; explaining that stakeholders requested the change. Accepted suggestion included rewording supported employment/day habilitation language related to transitioning to career exploration.

Two comments were received for Appx. B regarding reserved capacity and CCS monitoring. Slot categories were explained and the DDA agreed to consider provider capacity for TYs and Foster Kids. A CCS quarterly monitoring adjustment suggestion was accepted.

Twelve comments were received for Appx. C. A suggestion to include the title and form number of the Supportive Decision Making Agreement was not accepted as it is an agreement and not a standard form. A comment that provider applications not be required for providers of self-directed services, or individuals/businesses licensed in Maryland was not accepted. The DDA explained that applications are needed for providers where only budget authority is offered. The DDA provided clarification to comments regarding DDA approved/DDA certified vs licensed providers, and that a formal certification process is needed. The DDA explained that a formal provider approval process is in place for DDA providers to be certified or licensed. A comment that the Maryland Board of Nursing requirement of certification for unlicensed direct support providers is a hardship was received; the DDA explained this is Maryland law. Three comments regarding criminal background checks limiting community access were not accepted; DDA explained that criminal background checks are needed to protect waiver participants. The DDA did not accept suggestions to add a grandfather clause for participants who will no longer meet new language; that criteria for payments are removed; that service definitions are restrictive and overlapping; and State Plan policy language goes against waiver’s purpose. The DDA explained that service definitions give participants choice and flexibility and that accessing State Plan policy language is required by Centers for Medicare and Medicaid Services (CMS).

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The DDA received two comments for assistive technology and services. The DDA explained that DDA applications are not needed and that training requirements are required for assistive technology professionals who provide self-directed services.

Five comments were received regarding behavioral support services. One comment that behavior consultation service units be changed to 15 minutes were accepted. Two comments were affirmed, that only licensed professionals should oversee services. A comment stated that competency requirements are redundant and another recommended removing Functional Behavior Analysis and Antecedent Behavior Consequence language were not accepted. The DDA advised that competencies explain provider requirements for providing service and explained that Functional Behavior Analysis and Antecedent Behavior Consequence language would remain due to regulations.

Sixteen comments were received for career exploration. Suggestions to redefine, remove, or expand the time limit were received. The DDA clarified the time limit will not apply to those currently in service. The DDA received a suggestion to remove the Monday–Friday limit and clarified it is only for facility-based supports. Providers made comments related to competitive integrated employment, including creating an alternative that allows those who work but do not meet the definition. The DDA explained that assessing individual situations, as places may meet the community settings rule but not competitive integrated employment. The DDA did not accept a suggestion to remove the requirement for an employment goal from the service definition as the service is designed to create a path toward employment. Four comments were not accepted concerning CMS guidelines and excluding employment business and allow service flexibility; DDA clarified it is not excluding businesses but assessing situations individually using CMS guidance.

Fifteen comments were received for community development services. Advocates' recommendation that community development services should be available in the home was not accepted; participants can return home throughout the service for time-limited periods to address health and personal needs. Comments to include home-based employment and hobbies within the service were not accepted; employment supports can be offered through employment services. Comments to include educational programs and activities were not accepted, as access is included but does not cover associated costs. A comment that apprenticeships are excluded was not accepted as time-limited volunteering, internships and apprenticeships are covered. A suggestion to remove the four person limit was not accepted. A provider commented the service implies that staff remain with someone the whole time they are volunteering, which encourages dependence. The DDA explained that billing should occur for direct support and is not needed for independent volunteering. A comment that definitions makes billing complex was not accepted; definitions allow options for participants. Billing guidance is forthcoming. A suggestion that billing needs to include transportation was received; DDA clarified when billable. The DDA did not accept language edits that self-directed community development Services can be used with standalone transportation service. A provider asked DDA to clarify that community development services and employment services can be used on weekends and that day habilitation is only available Monday–Friday; the DDA confirmed the availability of these services as noted.

Four comments were received for community living—enhanced supports. A suggestion to expand on the types of clinicians an agency must contract with or have on staff was accepted. A provider recommend to supplement housing costs. The DDA explained it is reviewing the room and board and corresponding rates. A recommendation to fund vehicle purchases was received; the DDA explained that transportation is not a part of community living—enhanced supports.

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~~Three comments were received for community living—group homes. The DDA accepted a suggestion to include environmental supports. A provider suggested adding additional nursing funds for emergencies. The DDA explained that regional offices should be contacted in emergencies. A provider suggested removing discharge language related to nurse case management and delegation in community living—enhanced supports and community living—group homes. The DDA added language about health status change to current wording.~~

~~The DDA did not accept a recommendation that employment discovery and customization have employer and budget authority under self-direction; employment discovery and customization having budget authority ensures qualified providers.~~

~~Five comments were received for employment services. The DDA accepted a suggestion to clarify employment services overlap with residential services; guidance will be shared. The DDA explained 90 hours can be authorized up to twice a year to clarify job development limitations comment. A suggestion regarding billing concerns stated that a more flexible method of job development is needed and that separation of job development and support will not improve employment options. The DDA clarified Employment Services is designed to improve flexibility and rates will be considered with the rate study.~~

~~The DDA accepted a suggestion to include environmental assessments and modifications for people receiving community living—group homes.~~

~~Nine comments were received for individual and family directed goods and services. Comments suggested offering individual and family goods and services under the traditional service delivery model; to remove or increase the cap; to cover service animals and smartphones; and to cover classes and activities in the community were not accepted. The DDA will consider expanding the list of covered items in the future. Options are available through other Medicaid programs and other waiver services for service animals, smartphones, and community activities (classes). Comment suggested that service be flexible to support access to qualified providers. The DDA explained that providers and services are broad for inclusion of commercial businesses, community organizations, and licensed professionals.~~

~~A suggestion that the provider is responsible for sending a copy of the agreement for live-in caregiver was accepted. A suggestion was received to support self-directing participants with live-in unpaid caregivers; this is currently the case.~~

~~Two comments were received for medical day care. The DDA explained nursing services are currently covered in this service and the OLTSS will consider behavioral supports in medical day care.~~

~~One comment suggested allowing nurse case management and delegation during employment discovery and customization was not accepted as this service is time limited.~~

~~Two comments were received for participant education, training and advocacy supports. As transportation is included in participant education, training and advocacy supports; and standalone transportation service can be used, the suggestion to increase a cap was not accepted. The DDA explained that educational opportunities available outside of waiver services can also be explored, and did not accept a suggestion to increase the 10 hours/year limit.~~

~~The DDA received 22 comments for personal supports. One comment that personal supports is limiting and goes against person-centered planning. The DDA explained that personal supports is designed to complement waiver and other community services so participants receive needed~~

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supports. A suggestion to add language that emphasizes support was accepted. A suggestion to include travel time in the rate was received. The DDA explained the rate includes transportation but travel to and from the service cannot be billed. The DDA accepted a suggestion that service be offered anytime. Meaningful Day supports are not in session. There was a comment of disagreement with overnight supports being removed from service. The DDA explained that personal supports is designed to be habilitative and differs from personal care offered in the State plan. A suggestion that assistive technology be used to support overnight coverage will not work. The DDA explained that medical need for support can be received through the State plan and concerns should be shared with the regional office director for further assistance. Advocates expressed concerns about weekday time restrictions; the DDA stated that personal supports is not limited to weekdays. The DDA did not accept suggestions to redefine service to include companion and homemaker supports or cover service gaps between DDA and State plan. The DDA did not accept suggestions to exclude self-directing participants from 82 hour limit or increase the limit, as more hours can be authorized if there is an assessed need. Recommendation to support those currently receiving over 82 hours of supports was submitted. The DDA explained hours are authorized based on need. The DDA accepted the suggestion to include maintenance of skills and health management in the definition. The DDA accepted the suggestion to include language around the cost effectiveness and appropriateness of needs.

Advocates suggested that remote support services be offered under self-direction. The DDA confirmed this is the case.

There were eight comments for respite. Advocates suggested allowing overnight supports in the home be covered under respite; the DDA confirmed it this is covered. The DDA accepted comments suggesting raising the funding cap and separate camp dollars from overnight respite hours. The respite limitation was increased to 720 hours in addition to camp. A comment suggested to include specialized respite and behavioral respite homes was not accepted; services are provided under administrative contracts. The DDA did not accept a comment to suggest offering behavioral supports during respite, as it is time limited and behavior support services is offered through other services. The DDA did not accept a comment suggesting removal of training requirements for contractors or family staff. DDA must comply with the Maryland Board of Nursing requirements.

Twelve comments were received for shared living. The DDA accepted suggestions about adding “individual” as an arrangement and service provider. Comments suggesting allowance of family members, other than parents, the ability to provide this services and removing the criteria that states the participant not already have a family, allowance for this service be rendered in a family member’s home were not accepted. The DDA explained that this service is designed to support those without family support. The DDA did not accept suggestions that service have budget authority as it is not offered under self-direction. The DDA accepted a suggestion that service meet habilitative needs. Comments suggesting for continuing to support or grandfather host home providers that do not possess a GED certificate or high school diploma and historical homes that serve 3 clients, while the goal is to serve no more than 2, were accepted for current authorized homes. The DDA accepted a suggesting for removing the requirement for a shared living specialist; as assigning a specific specialist to the caregiver could push the relationship between the agency and contractor towards a supervisory or employee/employer relationship.

Fourteen comments were received for support broker. One suggestion that language should encourage use of support brokers; the DDA explained it supports self-direction and support broker use, but it is optional. Suggestions to change language regarding support broker roles and responsibilities to include day to day management of the plan, developing and implementing strategies, signing timesheets, establishing budgets, assisting with budget and employer authority;

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or hiring/firing workers were not accepted. The DDA explained support broker is designed to support self-direction participants by giving employer-related information and advice so the participant can make informed decisions about managing services. Advocates suggested adding that support broker be the primary advocate for participants; the DDA did not accept, as the participant has the freedom to choose their primary advocate. Recommendation that support broker differs from case management in intensity, frequency and level of detail was not accepted. The DDA stated each service is different and this could apply to all services. The DDA did not accept a suggestion to remove language regarding participants' significant health and medical changes, as wording relates to additional supports being authorized above the limit. Advocates expressed concerns that 4 hour limit not being person-centered; the DDA explained the State is required to outline scope, nature, and limits of each service. The DDA accepted a suggestion to remove provider qualifications numbers 9 through 13.

A comment suggested including businesses in a participant's home in supported employment. The DDA stated that it will develop guidance related to self-employment.

A recommendation that supported living has employer and budget authority under self-direction. The DDA explained that budget authority is offered.

Three comments were received for transition services. Comments involved supporting people moving into residential services, from their family's home or shelter, and from the community into services with a community residential provider. The DDA explained definition was developed per CMS guidance.

Thirteen comments were received for transportation. Advocate comments suggested transportation be a standalone service for those in self-direction whether or not they are receiving support from another service at that time; the DDA did not accept, explaining the service is designed to support independent travel and transportation is part of Meaningful Day and residential services. Comments suggesting removal of the words "independently" and "agreement" from the definition were not accepted; when used, "independently" indicates the person accesses their community without staff supports, and "agreement" clarifies specific details related to mileage reimbursement. Comments regarding family members and individual legally responsible being paid for service were not accepted. The DDA explained "legally responsible individuals" is used by CMS, and relatives can be reimbursed. One comment that reimbursement criteria limits community access. The DDA explained service is designed for independent travel in community. Providers recommendation to restore vehicle purchases to service was not accepted, as this service is designed for independent travel; transportation is a part of meaningful day and residential services. A comment that individuals providing service under self-direction do not need a DDA application, the DDA confirmed this is the case.

Four comments were received for Appx. D. The DDA accepted a suggestion to revise language regarding CCSs ensuring health and safety or service delivery to reflect their monitoring role. Recommendation to clarify how a person-centered plan (PCP) is developed including assessment information; the DDA clarified that the CCS is responsible for gathering information about requested services with participant/representative input, remaining members of the team may also provide information. One comment received asked DDA to describe "back-up" plan in detail was not accepted; the DDA explained information related to back-up plans is found in Appx. D-1e.

Forty-two comments were received for Appx. E. Comments included the separation of home and community-based services are impractical and not wanted; self-direction service options were reduced; and self-direction is being discouraged due to the term "traditional services." The DDA explained that service changes are based on stakeholder input; offer new opportunities; and

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service options have increased including support brokers services. The DDA explained there are two service delivery models offered and that CCSs support participants regardless of service delivery model. Recommendation to use “participant” or “participant/designated representative” throughout document, concerns about self-direction criteria and suggestions to remove designated representative language were received. The DDA explained CMS uses “participant” related to individuals enrolled; designated representative is not required. The DDA deleted criteria and added wording that participant or their designated representative being capable of making decisions. Suggestion to restore the federal Independence Plus designation was not accepted; CMS stated to remove. A comment stating the financial management service (FMS) request for proposal (RFP) references the wrong start date was clarified by the DDA; the RFP is expected to be released summer of 2019. Comment that FMS should be a waiver service instead of administrative was not accepted, as FMS has traditionally been an administrative service. Concerns that more than one FMS is needed because one FMS may be a monopoly were considered. The DDA clarified it has a joint RFP request with MDH partners to acquire a high quality FMS. Suggestions to revise FMS roles were not accepted as the DDA explained this service is designed to assist with employer and budget authority. Recommendation to change sentence about supports and protections were not accepted as the DDA explained it is a part of the amendment application template. A comment suggesting offering employer authority for employment discovery and customization, employment services, supported living, and to add shared living as a service with budget authority was not accepted as professional service standards and requirements have been established. The DDA accepted a suggestion to add the new self-direction manual’s release date. The DDA did not accept a comment related to the Self-Direction Service Agreement as it is part of the template. The DDA accepted comments that self-direction budgets align with traditional budgets. Advocates suggested allowing participants to modify services within their plan without DDA approval; the DDA did not accept as to support payment of qualified providers a modification is needed in the PCP. This is not an available option in the amendment application. All modification to the budget must be preceded by a change in the service plan. Concerns about the support broker service being optional and comments regarding the support broker role and responsibilities were not accepted. The DDA explained support broker service is designed to provide specific information, coaching, mentoring, and assistance, as necessary and appropriate, if chosen by the participant. Comment suggesting that self-direction be an option for those in residential with less than 4 others was not accepted; as a self-direction option is available for those who live with others under a lease. Concerns that excessive requirements on licensed/certified professionals and benefit limitations for support staff will limit access to qualified providers. The DDA explained that requirements ensure health and safety. Comment concerned that staff benefits are limited was clarified by the DDA; benefits are allowed under certain services based on the participant’s choice.

Two comments were received for Appx. F. A comment that new language lists five appeal topics that do not match up with the three topics mentioned in the introductory paragraph of Appendix F-1. The second comment sought clarification if appeal options were expanded, decreased or remained the same. The DDA clarified that language indicates how an individual and family are informed of their opportunity to request a Medicaid Fair Hearing and that appeal types remained the same.

The DDA accepted a comment for Appx. G to keep the word “approved” from standing committee role.

Sixteen comments were received for other matters. The DDA explained that services are designed to provide choice and flexibility in response to a comment that amendments are not flexible enough to address participants’ needs. The DDA explained its goal is to support participants to live in the least restrictive environment with family ties, if that is their choice in response to a

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~~comment for programs to help participants stay with their families. Parents suggested participants and parents/guardians are able to review the Supports Intensity Scale assessment (SIS) before submission. The DDA explained parents/guardians should work closely with the participant and assessor so all are informed of what is being submitted. The DDA stated it expects all providers to properly train their staff as outlined in COMAR in response to a comment that staff do not last long due to lack of training. A suggestion to use “participant” instead of “individual” throughout the waiver was not accepted as the DDA uses “individual” to describe someone in the application processes and “participant” describes those in services. A comment suggesting covering activity costs for day habilitation, community development services, personal supports, and community living was not accepted, as Medicaid waiver funds do not cover activity costs. A provider suggested adding an acuity factor to rates. The DDA explained that an acuity factor is not used as rates are developed based on definition, staff qualifications, and level of need. A recommendation to consider a rate in brick for job development indirect and direct services; the DDA explained this will be explored in the future. Comments were made that overlapping services will lead to billing errors and flexibility and rounding rules are needed. The DDA explained billing guidance will be provided based on a provider technical group’s suggestions. A comment was made that including transportation in rate compromises ability to retain qualified staff and access services. The DDA did not accept comments related to travel reimbursement for community development services and personal supports under self-direction, as travel is a part of Meaningful Day and residential rates. Transportation is also a standalone service for independent travel. A comment regarding needed support for recruiting/hiring staff and exploring personal and community interests was addressed. The DDA explained funds for recruitment are available through Individual and Family Directed Goods and Services and that Charting the LifeCourse™ tools and services are designed to assist with interests. The DDA stated the reimbursement rate includes staff wages and employee related expenses such as benefits in response to a comment regarding low wages and lack of benefits for direct support staff.~~

- J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State’s intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.
- K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services “Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons” (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

- A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Hutchinson
First Name:	Marlana R.
Title:	Deputy Director, Nursing and Waiver Services
Agency:	Maryland Department of Health – Office of Health Services

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Address :	201 West Preston Street, 1 st Floor			
Address 2:				
City:	Baltimore			
State:	Maryland			
Zip:	21201			
Phone:	(410) 767-4003	Ext:		<input type="checkbox"/> TTY
Fax:	(410) 333-6547			
E-mail:	marlana.hutchinson@maryland.gov			

- B.** If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Workman			
First Name:	Rhonda			
Title:	Director of Federal Programs			
Agency:	Maryland Department of Health – Developmental Disabilities Administration			
Address:	201 West Preston Street, 4 th Floor			
Address 2:				
City:	Baltimore			
State:	Maryland			
Zip :	21201			
Phone:	(410) 767-8692	Ext:		<input type="checkbox"/> TTY
Fax:	(410) 333-5850			
E-mail:	Rhonda.Workman@maryland.gov			

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are **readily** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: _____

State Medicaid Director or Designee

**Submission
Date:**

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

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Attachments to Application: 30

Last Name:	Neall				
First Name:	Robert R.				
Title:	Secretary				
Agency:	Maryland Department of Health				
Address:	201 W. Preston Street				
Address 2:	5 th Floor				
City:	Baltimore				
State:	Maryland				
Zip:	21201				
Phone:					
Fax:					
E-mail:					

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ Replacing an approved waiver with this waiver.
- ☐ Combining waivers.
- ☐ Splitting one waiver into two waivers.
- ☐ Eliminating a service.
- ☐ Adding or decreasing an individual cost limit pertaining to eligibility.
- ☐ Adding or decreasing limits to a service or a set of services, as specified in Appendix C.
- ☐ Reducing the unduplicated count of participants (Factor C).
- ☐ Adding new, or decreasing, a limitation on the number of participants served at any point in time.
- ☐ Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.
- ☒ Making any changes that could result in reduced services to participants.

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Attachment #1: Transition Plan

Specify the transition plan for the waiver:

The Community Pathways second amendment includes: (1) enhancement, clarifications, and addition to service descriptions related to scope, grouping and staffing; (2) the transition to the new fee-for-service payment methodology; and (3) the addition of procedure codes and associated rates related to grouping and staffing as outlined in the Amendment Purpose. Waiver service payment will fully transition to the LTSS Maryland system in on July 1, 2020.

To support the transition to these changes, the DDA will share information, guidance, and technical assistance with all stakeholders including through the DDA newsletter, transmittals, webinars, and face to face meetings. Coordinators of Community Services (CCS) will continue to share information with participants and families about new service opportunities and changes to existing services during their annual person-centered planning process and when new needs arise.

Transitions will occur in phases as outlined below.

TRANSITION PHASE #1 – DETAILED SERVICE AUTHORIZATION

Beginning July 1, 2019, the Person-Centered Plan (PCP) will include a new detailed service authorization section with all current and new waiver services (i.e. employment services and community living – enhanced supports) and proposed rates to be effective July 1, 2020. CCS will facilitate the annual person-centered planning process to identify the appropriate services related to individual goals and outcomes to support the person’s self-identified Good Life for services to begin July 1, 2020. Participants and families can explore various life focus areas (e.g. employment, community development, home and housing, health and wellness, etc.) at any time. The Supporting Families Community of Practice *Integrated Star* is a useful tool for people, families and teams to get a more comprehensive look at all the services and supports that may exist in a person’s life; not just eligibility specific supports and to then determine the most appropriate service(s) to support their assessed need(s) from among the new detail service options.

Participants currently receiving *Supported Employment* will be able to request job development, on-going supports, and/or follow along supports under the new *Employment Services* based on their assessed needs. Participants interested in *Employment Discovery and Customization* will also be able to request the discovery service under the new *Employment Services*. Participant’s interested in *Self-Employment* or *Co-Worker Supports* will also be able to request these services under the new *Employment Service*.

The new PCP detail services authorize including the new *Employment Services* will begin July 1, 2020 unless the person is included in Transition Phase #2 noted below.

Beginning July 1, 2019, participants self-directing services will be able to request the new *Individuals and Family Directed Goods and Services* options (i.e. therapeutic interventions to maintain or improve function including art, music, dance therapies) as per the service requirements outlined in Appendix C: regulations, and policies.

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TRANSITION PHASE #2 – SMALL GROUP TRANSITION TO FEE-FOR-SERVICE

Beginning December 1, 2019, a representative group of participants will be the first transitioned to the new *Employment Services, Day Habilitation Service* grouping (i.e. small and large groups), *Community Living Enhanced Supports*, and *Support Services* outlined within the new PCP detail service authorization. This will be done to ensure fiscal payment strategies used within LTSSMaryland are functional. This transition plan will support live testing of the new detailed service authorization and fee-for-service billing functionality in LTSSMaryland and the Medicaid Management Information System (MMIS) prior to implementing these changes. This testing is being done to reduce the risk of payment issues for all participants and providers.

The group of participants who will test the system will be from different regions and supported by various providers to support the transition to new services and the new fee-for-services payments. The initial group size will be small to ensure that there are adequate resources to quickly resolve issues, if they arise.

TRANSITION PHASE #3 – SHARED LIVING LEVELS

Participants receiving *Shared Living* services will transition to the new levels (i.e. Level 1, 2, and 3) in July 2020. The participants and their support network (including CCS and service providers) will identify the level of support needed during the annual person-centered planning process to support the person's self-identified Good Life as noted under Transition Phase #1. Billing under the new levels will begin July 2020.

TRANSITION PHASE #4 – PERSONAL SUPPORTS

Personal Supports services for individuals with complex medical and/or behavioral needs as indicated in the Health Risk Screening Tool, nursing care plan, and/or behavioral plan will be reimbursed at a higher rate beginning July 2020. The participant and their support network (including CCS and service providers) will identify the level of support needed during the annual person-centered planning process to support the person's self-identified Good Life as noted under Transition Phase #1.

TRANSITION PHASE #5 – FULL IMPLEMENTATION OF NEW SERVICES AND RATES

Beginning July 1, 2020, all groups of participants will begin to receive transition their meaningful day services including the new *Employment Services and Day Habilitation Service* grouping (i.e. small and large groups), residential services including *Community Living-Enhanced Supports*, and *Support Services* outlined within the new PCP detailed service authorization.

All *Supported Employment* and *Employment Discovery and Customization Services* transitions will end on June 30, 2020, and the new corresponding services (i.e. *Job Development, On-Going, and Discovery*) will begin on July 1, 2020 based on the PCP processes.

The Community Pathway amendment include various program related adjustment including the alignment of services scope, requirements, limitations, qualifications, and effective date for the three

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~~home and community-based service waivers programs that support individuals with developmental disabilities which includes the Family Supports Waiver, Community Supports Waiver, and the Community Pathways Waiver. It includes adjustment to the previously submitted service transition plan to support additional time for annual person-centered service exploration, planning, and service implementation. Coordinators of Community Services (CCS) will continue to share information with participants and families about new service opportunities and changes to existing services during their annual person-centered planning process and when new needs arise. It also adjusts some of the new or revised service implementation to provide additional time for rate setting and development of critical operational and billing functionality. Payment systems will transition to Maryland's Long Term Services and Supports (LTSS Maryland) system on July 1, 2020.~~

~~SERVICE ENHANCEMENTS AND TRANSITIONS—MEANINGFUL DAY SERVICES~~

~~Meaningful Day services include: Employment Services, Supported Employment, Employment Discovery and Customization, Career Exploration, Community Development Services, and Day Habilitation. A participant's Person-Centered Plan may include a mix of Meaningful Day services as provided on different days. Beginning July 2020, these services will be provided on an hourly basis providing new opportunities and flexibility for participants to receive various Meaningful Day services to meet their individualized goals on the same day.~~

~~Service changes will result in increased flexibility and opportunities for participants to receive more support hours of Meaningful Day services with the transition of service from a daily rate to an hourly rate. The rates will remain the same until new rates are finalized through the rate study.~~

~~Participants, family members, and Coordinators of Community Services (CCS) have been given guidance since July of 2018 to use their annual person-centered planning process to identify the appropriate service alignment related to their employment goals. This efforts has been through webinars, DDA's Employment First Newsletter, and regional provider meetings.~~

~~Beginning July 1, 2019, the Person-Centered Plan (PCP) will include a new detail service authorization section which includes the new employment services that will become available July 1, 2020. Participants receiving supported employment will be able to request job development, on-going, and/or follow along supports under the new employment services. Participants interested in employment discovery and customization will be able to request the discovery service under the new employment services. Participant's interested in self-employment or co-worker supports will also be able to request these services under the new employment service. Therefore, all supported employment and employment discovery and customization services will end on June 30, 2020 and the new corresponding services (i.e. job development, on-going, and discovery) will begin on July 1, 2020 based on the PCP processes.~~

~~Supported Employment~~

~~Supported Employment services will end on June 30, 2020 and transition to the new Employment Services.~~

~~Employment Services include discovery, job development, on-going job supports, follow along supports, self-employment development supports, and co-worker employment supports. Employment Services are based on Communities of Practice including new employment certifications requirements for staff qualification and new rates and payment reimbursement methodology based on the service scope and rate study including hourly, monthly, and milestone payments. This service will begin July 1, 2020. New service units (i.e. daily to hourly) and rates will be implemented on July 1, 2020.~~

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~~Participants previously receiving facility based, or small group, or large group supports under Supported Employment or Day services will transition to Career Exploration services by creating an employment goal within their Person-Centered Plan during their annual planning process that outlines how they will transition to community integrated employment (such as participating in discovery and job development).~~

~~Career Exploration will transition from a daily rate to an hourly rate on July 1, 2020. New service units (i.e. daily to hourly) and rates will be implemented on July 1, 2020.~~

~~Employment Discovery and Customization will end on June 30, 2020 and transition to the new Employment Services that includes discovery, job development, on-going job supports, follow along supports, self-employment development supports, and co-worker employment supports.~~

~~Community Learning Services new service units (i.e. daily to hourly) and rates will be implemented on July 1, 2020.~~

~~Day Habilitation new service units (i.e. daily to hourly) and rates will be implemented on July 1, 2020.~~

~~SERVICE ENHANCEMENTS AND TRANSITIONS—RESIDENTIAL SERVICES~~

~~Shared Living services have been enhanced to support participants with increase needs.~~

~~Community Living Group Home new service rates will be implemented July 1, 2020.~~

~~Community Living Enhanced Supports new service will be implemented on July 1, 2020.~~

~~Supported Living is a new service that provides participants with a variety of individualized services that support living independently in the community beginning July 2019.~~

~~SERVICE ENHANCEMENTS AND TRANSITIONS—SUPPORT SERVICES~~

~~Behavioral Support Services changes include:~~

~~Provider qualifications and staff requirements were enhanced. Current providers will have up to twelve months to meet the new requirements. Qualified clinicians who complete the behavioral assessment and consultation must have:~~

- ~~1. A minimum of one year of clinical experience under the supervision of a licensed Health Occupations professional with training and experience in functional analysis and tiered behavior support plans with the I/DD population;~~
- ~~— A minimum of one year clinical experience working with individuals with co-occurring mental health or neurocognitive disorders; and~~
- ~~2. Competencies in areas related to:~~
 - ~~(-) Analysis of verbal behavior to improve socially significant behavior;~~
 - ~~(-) Behavior reduction/elimination strategies that promote least restrictive approved alternatives, including positive reinforcement/schedules of reinforcement;~~
 - ~~(-) Data collection, tracking and reporting;~~
 - ~~(-) Demonstrated expertise with populations being served;~~
 - ~~(-) Ethical considerations related to behavioral services;~~
 - ~~(-) Functional analysis and functional assessment and development of functional alternative behaviors and generalization and maintenance of behavior change;~~

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- ~~(-) Measurement of behavior and interpretation of data, including ABC (antecedent behavior-consequence) analysis including antecedent interventions;~~
- ~~(-) Identifying desired outcomes;~~
- ~~(-) Selecting intervention strategies to achieve desired outcomes;~~
- ~~(-) Staff/caregiver training;~~
- ~~(-) Support plan monitors and revisions; and~~
- ~~(-) Self management.~~

~~Nurse Case Management and Delegation Services are included in the Community Living—Group Home, Community Living—Enhanced Supports, Supported Living, and Shared Living services. If additional training supports are needed because of a change in condition after discharge from a hospital or skilled nursing facility, the request is reviewed by DDA’s regional office and additional standalone Nurse Case Management and Delegation Service support service hours can be authorized.~~

~~Personal Supports changes include:~~

- ~~0. Transportation cost associated with the provision of services will be covered within the new rate effective July 2020.~~
- ~~0. Personal Support Services rate will remain the same until new rates are finalized through the rate study. New rates will be implemented on July 1, 2020.~~

~~Respite Care Services changes include:~~

- ~~0. A daily rate will be used for licensed sites and hourly rate for in/out of home services.~~
- ~~0. The service limit has been increased to include a daily/hourly limit up to 720 hours/year plus up to \$7,248 toward camps.~~
- ~~0. Participants authorized above the renewal service limit prior to July 1, 2018 can continue to receive their previously authorized service level until their annual person-centered plan effective date. This will support additional time for person-centered service exploration, planning, and service implementation. Participants seeking habilitation supports as an alternative to the basic break from the daily routine can seek additional Meaningful Day and Personal Support services.~~
- ~~0. Adjustment to staff qualifications include removing the GED or High School Diplomas requirement and adjusting the age requirements to 16 years.~~

SELF DIRECTION

~~Support Broker services will be an optional waiver service.~~

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and

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transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The State assures this waiver amendment or renewal will be subject to any provisions or requirements included in the State's most recent and/or approved home and community-based settings Statewide Transition Plan. The ~~state~~ State will implement any CMCS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

<input checked="" type="radio"/>	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (<i>select one</i>):	
<input type="radio"/>	The Medical Assistance Unit (<i>specify the unit name</i>) (<i>Do not complete Item A-2</i>)	
<input checked="" type="radio"/>	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit. Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency. (<i>Complete item A-2-a</i>)	Developmental Disabilities Administration (DDA)
<input type="radio"/>	The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency. Specify the division/unit name:	
	In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (<i>Complete item A-2-b</i>).	

2. **Oversight of Performance.**

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities.

The Maryland Department of Health (MDH) is the Single State Medicaid Agency (SMA) authorized to administer Maryland's Medical Assistance Program. MDH's Office of Long-Term Services and Supports (OLTSS) is the Medicaid unit within the SMA that oversees the Community Pathways Waiver. In this capacity, OLTSS oversees the performance of the Developmental Disabilities Administration (DDA), Operating State Agency (OSA) for the waiver. The OLTSS serves as the point of contact with the Centers for Medicare and Medicaid Services (CMS) with programmatic expertise and support from DDA.

The DDA is responsible for the day-to-day operations of administering this waiver, including but not limited to enrolling participants into the waiver, reviewing and approving community-based agencies and licensure applications for potential providers, monitoring claims, and assuring

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participants receive quality care and services based on the assurances requirements set forth in this waiver. The DDA is responsible for collecting, trending, prioritizing and determining the need for system improvements.

OLTSS will meet regularly with DDA to discuss waiver performance and quality enhancement opportunities. Furthermore, the DDA will provide OLTSS with regular reports on program performance. In addition, OLTSS will review all waiver-related policies issued. OLTSS will continually monitor DDA's performance and oversight of all delegated functions through a data-driven approach. If any issues are identified, OLTSS will work collaboratively with DDA to remediate such issues and to develop successful and sustainable system improvements. OLTSS and the DDA will develop solutions guided by waiver assurances and the needs of waiver participants. OLTSS will provide guidance to DDA regarding recommended changes in policies, procedures, and systems.

A detailed Interagency Agreement (IA) outlines the roles and responsibilities related to waiver operation and those functions of the division within OLTSS with operational and oversight responsibilities.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

Not applicable

- 3. Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

<input checked="" type="radio"/>	<p>Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. <i>Complete Items A-5 and A-6.</i></p> <p>As further described below, the DDA currently contracts with community organizations for assistance and services in the following areas: (1) Participant Waiver Applications; (2) Support Intensity Scale (SIS)®; (3) Quality Assurance; (4) System Training; (5) Research and Analysis; (6) Fiscal Management Services (Agency with Choice); (7) Health Risk Screening Tool; (8) MD-Long Term Services and Supports Information System; and (9) Behavioral and Mental Health Crisis Supports.</p> <p>1. Participant Waiver Application The DDA contracts with independent community organizations and local health departments as Coordinators for Community Services to perform intake activities, including taking applications to participate in the waiver and referrals to county, local, State, and federal programs and resources.</p> <p>2. Support Intensity Scale (SIS)®</p>
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	<p>The DDA contracts with an independent community organization to conduct the Support Intensity Scale SIS®. The SIS® is an assessment of a participant's needs to support independence. It focuses on the participant's current level of support needs instead of focusing on skills or abilities they may not currently demonstrate. The Coordinators of Community Service use each completed SIS® as a planning guide in the development of the participant's Person-Centered Plan.</p> <p>3. Quality Assurance The DDA contracts with independent community organizations to conduct and analyze results from the National Core Indicator (NCI) surveys. The DDA will be contracting for a Quality Improvement Organization–like organization to support administrative functions related to technical assistance, quality assurance, and utilization review.</p> <p>4. System Training The DDA contracts with independent community organizations to provide trainings for individuals, their family members, community providers, Coordinators of Community Services, Support Brokers, DDA staff, and others related to various topics to support service delivery (i.e. person-center planning), health and welfare (i.e. choking prevention), and workforce development (i.e. alternative communication methods).</p> <p>5. Research and Analysis The DDA contracts with independent community organizations and higher education entities for research and analysis of waiver service data, trends, options to support waiver assurances, financial strategies, and rates.</p> <p>6. Fiscal Management Services The DDA contracts with independent community organization for fiscal management services to support participants that are enrolled in the DDA's Self-Directed Services Model, as described in Appendix E.</p> <p>7. Health Risk Screen Tool The DDA contracts with Health Risk Screening, Inc. for training and the use of an electronic Health Risk Screen Tool (HRST) to identify health and safety risk factors for participants and to assist with determining health related support needs and training.</p> <p>8. LTSS Maryland - Long Term Services and Supports Information System The MDH contracts with information technology organizations for design, revisions, and support of the database that supports waiver operations.</p> <p>9. Behavioral and Mental Health Crisis Supports The DDA contracts with independent community organizations for crisis hotline services, mobile crisis services, and behavioral respite services to support participants and families during behavioral and mental health crisis.</p> <p>10. Organized Health Care Delivery System providers Participants can select to use an Organized Health Care Delivery System (OHCDS) provider to purchase goods and services from community agencies and entities that are not Medicaid providers. The OHCDS provider's administrative for the action is not charged to the participant.</p>
○	<p>No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).</p>

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4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select one*):

<input checked="" type="radio"/>	Not applicable
<input type="radio"/>	Applicable - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
<input type="checkbox"/>	Local/Regional non-state public agencies conduct waiver operational and administrative functions at the local or regional level. There is an interagency agreement or memorandum of understanding between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these agencies and complete items A-5 and A-6:</i>
<input type="checkbox"/>	Local/Regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these entities and complete items A-5 and A-6:</i>

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The DDA is responsible for monitoring all contracts pertaining to administration and operations supporting this waiver.

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The DDA has a dedicated procurement function providing oversight of all legal agreements, including contracts and memoranda of understanding, into which the DDA enters.

Standard practice includes assignment of a contract monitor to provide technical oversight for each agreement, including specific administration and operational functions supporting the waiver as required in the agreement. Performance and deliverable requirements are set forth in each agreement, delineating service expectations and outcomes, roles, responsibilities, and monitoring.

DDA staff monitor each agreement and assess contract performance on an ongoing basis, depending on the specific contract requirements, but no less frequently than annually.

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1. Participant Waiver Application – DDA reviews all applications daily for completeness as per DDA policy and provide technical assistance, training, or request corrective action as needed.
2. Support Intensity Scale (SIS)® - DDA's contract monitor reviews submitted invoices and documentation monthly related to completed Support Intensity Scale SIS®. Corrective actions are taken for discrepancies.
3. Quality Assurance – DDA's contract monitor reviews submitted data with the National Core Indicator (NCI) Reports upon receipt and initiates corrective actions as needed.
4. System Training – DDA staff review supporting documentation including attendance sheets upon receipt prior to approval of invoices.
5. Research and Analysis – DDA staff review activity reports and supporting documentation upon receipt prior to approval of invoices.
6. Fiscal Management Services – DDA staff conducts audits of FMS records for compliance with operational tasks annually and provide technical assistance, training, or request corrective action as needed.
7. Health Risk Screen Tool – DDA's contract monitor reviews submitted invoices and documentation related to completed HRSTs upon receipt prior to approval of invoices. Corrective actions are taken for discrepancies.
8. Maryland - Long Term Services and Supports Information System – DDA staff review and authorize service deliverables based on work orders upon receipt.
9. Behavioral and Mental Health Crisis Supports - DDA's contract monitor reviews submitted invoices and documentation related to delivered services as per the contract upon receipt prior to approval of invoices. Corrective actions are taken for discrepancies.
10. Crisis hotline services, mobile crisis services, and behavioral respites services - DDA's contract monitor reviews submitted invoices and documentation related to delivered services as per the contract upon receipt prior to approval of invoices. Corrective actions are taken for discrepancies.
11. Organized Health Care Delivery System providers - DDA audits service providers annually for compliance with DDA policy and regulation and provide technical assistance, training, or request corrective action as needed.

Assessment results will be shared with OLTSS during monthly meetings.

- 7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that*

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Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities..

i Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver*

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- *Equitable distribution of waiver openings in all geographic areas covered by the waiver*
- *Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014).*

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	AA - PM1: Number and percent of annual Quality Reports submitted by DDA, to the OLTSS, in the correct format and timely. N = # of Quality Reports submitted by DDA in the correct format and timely. D = # of Quality Reports required by the OLTSS.		
Data Source (Select one) (Several options are listed in the on-line application): Other			
If 'Other' is selected, specify: DDA Quality Report			
	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:
Performance Measure:	AA - PM2: Number and percent of providers with Medicaid Provider Agreements that are executed in accordance with standards established by the Medicaid agency. N = # of providers with Medicaid Provider Agreements that are executed in accordance with standards established by the Medicaid agency. D = # of providers		
Data Source (Select one) (Several options are listed in the on-line application): Reports to State Medicaid Agency on delegated Administrative functions			
If 'Other' is selected, specify:			
	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)

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	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Performance Measure:

AA - PM3: Number and percent of waiver policies approved by the OLTSS. N = Number of waiver policies approved by the OLTSS D = Total number of waiver policies issued.

Data Source (Select one) (Several options are listed in the on-line application): Presentation of policies or procedures

If 'Other' is selected, specify:

	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Performance Measure:

AA - PM4: Number and percent of quarterly meetings held over a fiscal year to specifically monitor progress of performance measures. N = # of quarterly meetings held during the fiscal year that focused on monitoring of performance measures. D = # of quarterly meeting scheduled during the fiscal year.

Data Source (Select one) (Several options are listed in the on-line application): Meeting Minutes

If 'Other' is selected, specify:

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	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Performance Measure:	AA - PM5: Number and percent of Type 1- Priority A incidents of abuse, neglect or exploitation reviewed that did not require technical assistance or intervention by the OLTSS. N = # of Type 1 - Priority A incidents of abuse, neglect or exploitation reviewed that did not require technical assistance or intervention by the OLTSS. D = Number of Type 1 - Priority A incidents of abuse, neglect or exploitation reviewed by the OLTSS.
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Data Source (Select one) (Several options are listed in the on-line application): Other

If 'Other' is selected, specify: PCIS2 PORH Module

	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input checked="" type="checkbox"/> Other Specify: Office of Health Care Quality	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Performance Measure:	AA - PM6: Number and percent of on-site death investigations conducted by the OHCQ that met requirements. N = # of on-site death investigations reviewed by the OHCQ the met requirements. D = # of on-site death investigations reviewed by the OHCQ
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Data Source (Select one) (Several options are listed in the on-line application) Record Review, on site

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<i>If 'Other' is selected, specify:</i>			
	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

- ii If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

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b. Methods for Remediation/Fixing Individual Problems

- i Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The Office of Long-Term Services and Supports (OLTSS) within the State Medicaid Agency (SMA) is responsible for ensuring that the DDA performs its assigned waiver operational and administrative functions in accordance with the waiver requirements. To this end, OLTSS has developed communication and reporting mechanisms to track performance measures as detailed herein.

The DDA submits an Annual Quality Report to OLTSS. It is a report on the status of waiver performance measures and includes discovery findings, remediation strategies, challenges, and system improvements associated with each waiver assurance including Level of Care, Service Plan, Qualified Providers, Health and Welfare, Financial Accountability, and Administration. The report includes any barriers to data collection and remediation steps. The OLTSS, upon review of the report, will meet with DDA to address problems and barriers. Guidance from OLTSS to DDA regarding changes in policies, procedures, or other system changes will be dependent upon the problems or barriers identified. OLTSS and DDA communicate regularly and meet quarterly to discuss performance measures. If problems are identified regarding delegated functions, OLTSS and DDA develop solutions guided by waiver assurances and the needs of waiver participants with OLTSS exercising ultimate authority to approve such solutions.

- ii **Remediation Data Aggregation**

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Remediation-related Data Aggregation and Analysis (including trend identification)	Responsible Party (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
		<input type="checkbox"/> Continuously and Ongoing
		<input type="checkbox"/> Other Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

<input checked="" type="radio"/>	No
<input type="radio"/>	Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

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